The John W. McCormack Institute of Public Affairs

An Occasional Paper

Hospital Mergers and Access to Reproductive Healthcare

Examining the Issue of Catholic/non-Catholic Mergers and Affiliations in Massachusetts

by
Maureen E. Jerz
Master of Science in Public Affairs
John W. McCormack Institute of Public Affairs
University of Massachusetts Boston

Outstanding Case Study Award for Class of 2001

January 2002

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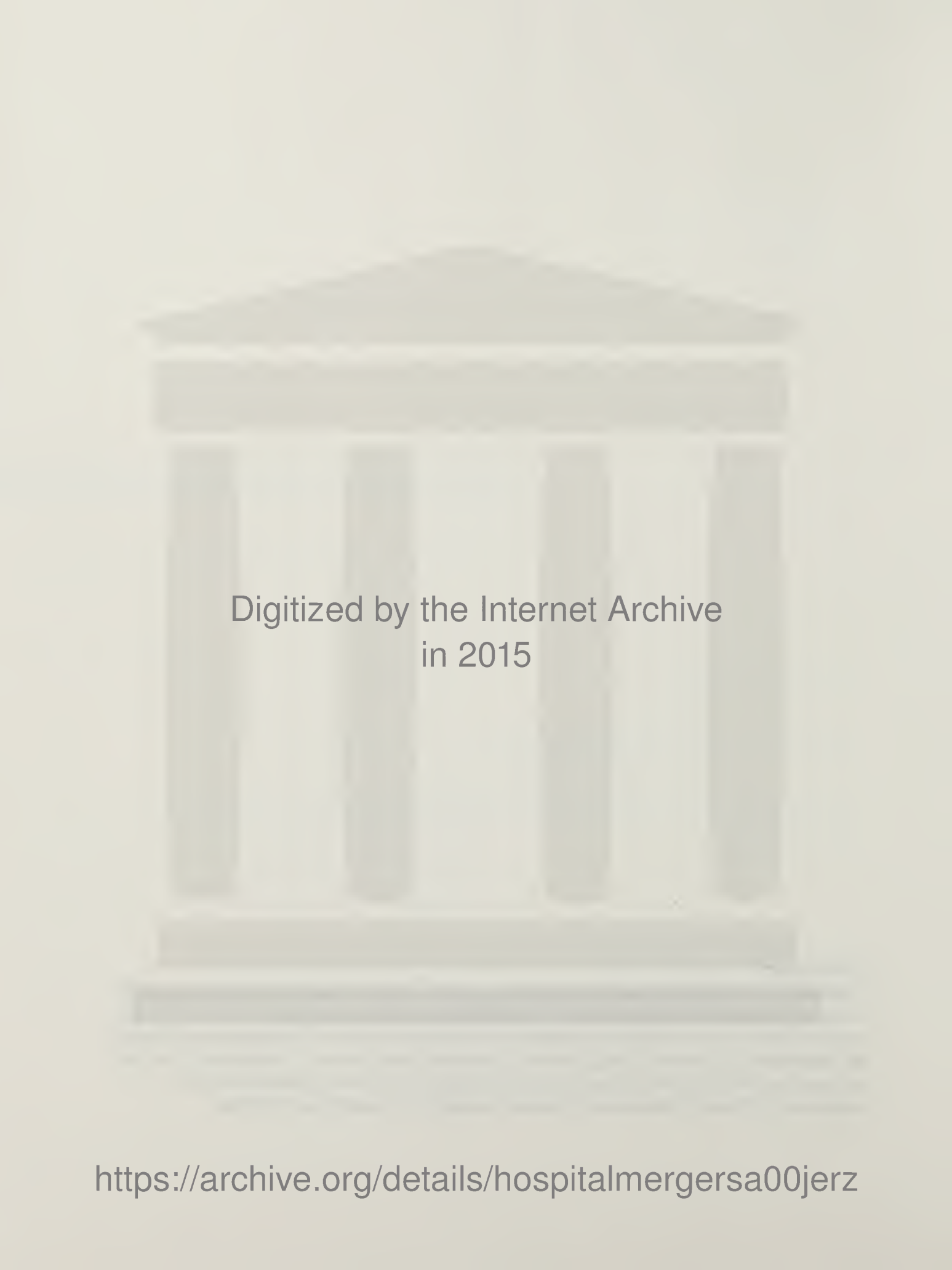

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ABSTRACT

Hospital Mergers and Access to Reproductive Health Care
Examining the Issue of Catholic/non-Catholic Mergers and Affiliations in Massachusetts

This case study focuses on the policy issues that arise in Massachusetts relative to the right to access reproductive health care services, when hospitals owned by Catholic health care corporations merge with secular hospitals. Catholic hospitals must abide by *The Ethical and Religious Directives for Catholic Health Care Services,* a set of values based frameworks that guide the delivery of health care services in Catholic hospitals and other Catholic health care institutions. The *Directives* prohibit Catholic health care institutions from performing certain reproductive health care services, such as abortion, contraception, in vitro fertilization, sterilization, and emergency contraception, including emergency contraception in the case of rape. In a health care system where barriers to receiving reproductive care are already a significant factor for many women, the potential effects of this additional barrier to accessing reproductive health care services need to be examined.

The study examines two Massachusetts mergers: the 1997 merger between the Neponset Valley Health System and Caritas Christi Healthcare System, and the attempted affiliation in 1994/95 of Holyoke Hospital and Providence Hospital, which is owned by Sisters of Providence Health Systems. In each case, available reproductive services pre and post merger are delineated. Participants in all levels of the merger process are interviewed. Existing Massachusetts law governing mergers is examined.

The study finds that in Massachusetts, public policy has evolved over time relative to these mergers. In 1994, the body of public policy was not sufficient enough to support the claim that loss of reproductive services was a significant enough issue to warrant concern in relation to this type of merger. By 1997, a shift had occurred in the way this issue was perceived by those charged with the policy-making decisions relative to mergers of this type. The study concludes that policy around the issue of mergers and access to reproductive health care must ensure public participation, must support the implementation of best practices in the field of women's health care, and must hold health care institutions accountable for planning around replication of any services lost through a merger or affiliation.

INTRODUCTION

The purpose of this case study is to focus on the policy issues that arise relative to the right to access reproductive health care services, when hospitals owned by Catholic health care corporations merge with secular hospitals. Because Catholic hospitals must abide by the *Ethical and Religious Directives for Catholic Health Care Services*, following this type of merger previously secular hospitals are, in most instances, required to follow the *Directives.* The *Directives* prohibit Catholic health care institutions from performing and/or providing certain reproductive health care services such as abortion, contraception, in vitro fertilization, sterilization, and emergency contraception, including emergency contraception in the case of rape. In a health care system where barriers to receiving reproductive care are already a significant factor for many women, the potential effects of this additional barrier to accessing reproductive health care services need to be examined.

The study will examine two Massachusetts mergers: the 1997 merger between The Neponset Valley Health System and Caritas Christi Healthcare System, and the attempted merger in 1994/95 of Holyoke Hospital and Providence Hospital, which is owned by Sisters of Providence Health Systems. In each case, available reproductive services pre and post merger will be delineated. Additionally, participants in the merger process, including state lawmakers, representatives of both Catholic and secular health organizations, community coalition members, and members of other advocacy groups will be interviewed. Existing Massachusetts law governing mergers will be examined. Using the information gathered through this process, the study will try to answer the

following public policy question: What policies need to be in place in order to ensure that individuals can access the reproductive services to which they are entitled by law, in a system in which the rights of the providers of those services to refuse delivery on religious grounds are also protected by law.

BACKGROUND

National Trends: Increasing Merger Activity

In this decade, as health care organizations have scrambled to maintain economic viability in the wake of the failed Clinton health plan, hospitals, in an effort to contain costs and consolidate resources, have merged at record rates. Dubbed by some as "merger mania," (Applebaum, p1) this phenomenon has generated concerns among health care advocates relative to access and quality of care. Mergers that involve the sale of non-profit institutions to for-profit corporations have generated the highest level of concern and scrutiny. Increasingly however, one other type of merger has come under scrutiny, and that is the merger or affiliation of secular institutions with Catholic health care organizations. Advocacy groups have raised questions about access to reproductive health care in relation to these types of mergers. In particular, several groups, Catholics for Free Choice, of Washington, D.C., Mergerwatch, based in New York, the Reproductive Freedom Project of the American Civil Liberties Union, and the National Women's Law Center, of Washington, D.C., have been following and documenting the numbers of Catholic/non-Catholic mergers, and any resultant effect on access to reproductive care.

How Are Catholic Mergers Different?

Catholic health care organizations follow what are know as the "*Ethical and Religious Directives for Catholic Health Care Services.*" (Reproductive Health Compromised, p.10) When a secular hospital is bought by or affiliates with a Catholic health care organization, the resulting merged institution must follow, generally as a condition of the merger, these *Directives*. In fact, Directive #5 under Part One: The Social Responsibility of Catholic Health Care Services states the following:

> "Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel." (Directives, p.7)

The *Directives*, which provide Catholic health care institutions with doctrine based frameworks from which they must operate, prohibit the provision of abortion, contraceptive services, infertility treatment, sterilization procedures, and emergency contraception, including its use in the case of rape. (Appendix A)

Conscience Clauses

Adding to the problem has been a recent inclination towards the creation of legislation at both the state and federal level around the issue of religious or conscientious exemption from anti-discrimination laws. Commonly known as "conscience clauses," these legislative efforts allow both religious and secular entities to decline provision of certain services if the service in question "would interfere with their right of conscience." (American Civil Liberties Union, 1999) Organizations or individuals claiming conscience clauses are protected from anti-discrimination laws and thus may be exempt

from the threat of being charged with discrimination if they refuse to provide a service to which they have a moral or religious objection. Thus religious institutions, like Catholic health care institutions, may refuse to provide certain reproductive services without the threat of a gender based discrimination lawsuit.

The Size of Catholic Health Care

By some accounts, Catholic health care systems are growing, although the Catholic Health Association (CHA) disputes this. According to a publication by the advocacy group Catholics for Free Choice, which cites Modern Healthcare as its source, "five of the nation's ten largest health care systems, as measured by net patient revenues, are Catholic." (Bucar, 1998, p.13) Additionally, while merger activity in general had slowed somewhat by 1998, "mergers involving Catholic hospitals tripled over the previous year." (Bucar, 1999, p.5) And according to an American Civil Liberties Union report, "The Catholic health system alone is the largest single private sector health care provider in the United States. It includes more than 600 hospitals, 200 health care centers, and 1500 specialized care facilities, such as drug treatment centers. Catholic hospitals serve approximately 50 million patients a year." (The American Civil Liberties Union, 1995)

The Catholic Health Association however disputes statistics gathered by Catholics For Free Choice regarding the growth of Catholic health care. In a letter to the *Wall Street Journal*, Rev. Michael Place, president and CEO of CHA writes,

> "In reality, when you compare all investor-owned systems with all Catholic systems, both grew by the nearly identical 12 percent...Contrary to claims by Catholics for Free Choice, Catholic hospitals accounted for 10 percent f the nation's community hospitals in the early 1980s and for 10 percent

> of the nation's community hospitals today. In fact, Catholic healthcare has not been immune from the general trend of hospital closures. There are fewer Catholic hospitals today than 10 years ago." (Catholic Health World, 1999)

National Trends: Barriers to Reproductive Healthcare Access

During the second half of this century, strides were made in the provision of easily accessible health care for women, particularly in the area of reproductive health care. In the larger debate about health care reform, the issues around systemic cost and access to affordable coverage are most frequently discussed. While these issues certainly impact health care for women, imbedded within these issues are factors, which specifically affect women, particularly low-income women, and their access to health care in general and reproductive health care in particular. Beginning in the 1980's, these political, social, and economic factors have come together in such a way as to slowly erode this past progress.

Almost since its passage in 1973, the Roe vs. Wade decision, which gave women the right under the Constitution's provision of privacy to decide whether to continue a pregnancy, has been under attack. (Reagan, p.54) Beginning with the Hyde Amendment, which was passed in 1976 and limited use of federal Medicare funds for abortion, political pressure to overturn Roe reached its height in the 1980's during the Reagan and Bush administrations. Five Supreme Court Justices were appointed during the Reagan/Bush administrations, and none of the five appointees support a strict scrutiny of Roe. (Center for Reproductive Law and Policy, p.7)

A strict scrutiny standard means that the right to choose, and thus women's reproductive liberties were afforded the highest level of constitutional protection, a fundamental right (similar to the right to freedom of speech or religion) to privacy.

However, the formulation of abortion "as a negative right-the right to have the government leave you alone-rather than as an affirmative right-the right to have access to a health care choice," (Kolbert, p.95-99) left this decision open to attack. Those five justices have over the past few years interpreted the *Roe* decision to mean that the government may impose restrictions on that right to privacy, as long as those restrictions do not pose an "undue burden" on a women's right to choose. (Wilder, p.85) These five justices still constitute a majority on this issue, and will take up the issue of late term abortion this year. Access to safe, legal abortion, and thus a women's right to control her life as far as reproductive choices are concerned, an issue that is fundamental to a women's reproductive health, is in serious jeopardy of being curtailed or eliminated.

Social factors also limit women's access to health care services. Nationwide, 14% of women are uninsured, (Making the Grade, p.3) and the percentage of uninsured amongst low income and minority women is higher. For women on Medicaid, contraceptive, family planning and abortion coverage may be limited. In fact, "some states actively block women's access to full reproductive health care services through policies such as waiting periods, bans on medically approved procedures and funding restrictions for abortion services." (Making the Grade, p. 6) Geographic, language and childcare barriers may also reduce access. Significant numbers of women live in areas in which there is no easily accessible abortion provider, with one publication reporting that 86% of U.S. counties are without an abortion provider. (The Abortion Access Project, p.1) Issues related to violence at clinics that provide abortion services in conjunction with other reproductive health care services have further exacerbated the access problem, as those clinics close, leaving a gap not only in the provision of abortion services, but

other reproductive services as well. Finally, recent research has shown that women's health care "is fragmented in its delivery, particularly with regard to the separation of reproductive and non-reproductive services." This fragmentation creates a barrier to the delivery of comprehensive and integrated health care services. (Weisman, 1998)

Economically, the reliance on a fee for service system of private insurers, the governments open ended entitlement programs of Medicare and Medicaid, and increasing drug and technology costs have caused health care spending to skyrocket. In 1950, health care spending accounted for 4.5% of the country's Gross Domestic Product. In 1992, that figure had grown to the point where it accounted for 14% of the Gross Domestic Product. (Ginzberg, p.11) These increases are passed on to insurance carriers (mainly employers) and their customers in the form of higher premiums. As premiums increase, employers try to control costs by either requiring employees to pay a higher percentage of their premiums, thus pricing some employees out, or by hiring temporary or part-time employees who are not eligible to receive health care benefits. Because women are more reliant on part-time, temporary, and low paying employment, they are disproportionately affected by this country's reliance on employer sponsored health care insurance. (Hafner-Eaton, p.245)

MASSACHUSETTS HEALTH CARE CLIMATE

While known throughout the world for the quality of its health care services, Massachusetts has also struggled with a rapidly changing health care market. In the last ten years, Massachusetts, like many other states, has been faced with the following health care issues:

- Devolution of health care reform to the states
- A changing HMO landscape and the emergence of managed care
- Rising numbers of uninsured/underinsured
- A move towards deregulation followed by a call for increased government involvement
- Patients as consumers
- A shift away from hospitalization as the centerpiece for patient care
- Increasing numbers of hospital mergers and affiliations (Massachusetts Health Care Trends, pp. 1-4)

Between 1990 and 1999, Massachusetts has seen 19 acute hospital closures/conversions. (Massachusetts Health Care Trends, pp. 83-89) Of these, three involved mergers or affiliations between Catholic and non-Catholic institutions. (Massachusetts Health Care Trends, pp .95-99) There are seven hospital systems in Massachusetts, which incorporate 31 hospitals. Of the seven, one system is Catholic owned and consists of six hospitals. (Massachusetts Health Care Trends, p.93)

Massachusetts faired well compared to other states on a recent nationwide assessment of women's health services, ranking third in the nation. However it still received an overall score of unsatisfactory (no state in this survey received a satisfactory grade) based on 64 status and policy indicators related to women's access to health care, wellness and prevention, key health conditions, and living in a healthy community. (National Women's Law Center, p. 56) And while this report gives Massachusetts a grade of satisfactory in the status indicator related to the percentage of women living in a county which does not have a abortion provider (National Women's Law Center, p. 56), a report by the Abortion Access Project cites "a shortage of abortion services outside of

the 3 urban areas of Boston, Worcester, and Springfield, especially for low-income women." (The Abortion Access Project, p.1)

TWO MASSACHUSETTS MERGERS

Chronology of the Holyoke and Sisters of Providence Deal

Background on Holyoke Hospital and Providence Hospital

Both Holyoke Hospital and Providence Hospital are located in Holyoke, Massachusetts. Providence Hospital, which is owned by The Sisters of Providence Health Systems (SPHS), was at the time of the proposed affiliation (1994) an acute care facility with 202 beds and 834 employees. This Catholic health care organization had been in operation since 1873 (McAuliffe, 1994). Holyoke Hospital was and is still owned by Holyoke-Chicopee Area Health Resources Incorporated (HCAHR), had 250 beds, 1083 employees, and was 101 years old in 1994. (McAuliffe, 1994) The city of Holyoke, with a percapita income of $11,088 (Commonwealth of Massachusetts Department of Revenue) and almost 75% of its school children eligible for free or reduced lunch (School District Profiles) is one of the poorest cities in Massachusetts. In 1990, (pre- merger discussions) the teen birth rate in Holyoke was the highest in the State at 140 per 1000 females ages 15-19. In 1999 (most recent statistics), Holyoke is third in the State in teen birth rate at 100 per 1000 females ages 15-19. (Appendix B) (Adolescent Births, p.53)

The Planned Affiliation of Providence Hospital and Holyoke Hospital

In February of 1994, Providence Hospital and Holyoke Hospital announced an intention to affiliate. (Pugh, 1994) According to Vincent McCorkle, president and CEO of Providence Hospital, this decision was reached after a community needs stuy confirmed what had long been suspected, that there was an overcapacity of acute care beds, and an undercapacity of behavioral health services in the city of Holyoke. (interview, McCorkle, 2001) Hank Porten, CEO of Holyoke Hospital also pointed to market pressures as the determining factor in exploring an affiliation with Providence Hospital. "The market could not support two hospitals. We needed to give it (an affiliation) a good look to see what could be done," said Porten. (interview, Porten, 2001) By affiliating with each other, both hospitals hoped to be able to provide more cost effective health services to area residents. Acute care services would be consolidated at Holyoke Hospital, and behavioral health services would be consolidated at Providence Hospital. By consolidating acute care services at Holyoke Hospital, these services would now be delivered in accordance with the Catholic *Directives.* The people of Holyoke would no longer have a choice, within their community, of selecting a religious or secular health care setting. And according to the Memorandum of Understanding filed by the two institutions in March of 1994, following the affiliation:

> "The activities of Holyoke and the other HCAHR Affiliates will at all times be conducted in a manner which conforms to the Ethical and Religious Directives for Catholic Health Facilities as may from time to time be approved by the National Conference for Catholic Bishops. Holyoke will no longer perform abortions. Holyoke may perform sterilization procedures only when determined to be medically necessary."(Memorandum of Understanding, p.7)

In order to receive health care services in a secular setting, citizens of Holyoke would have to travel the 10-15 miles to Springfield, Massachusetts, where Baystate Medical Center is located.

The Affiliation Deal and Reproductive Access Issues

In announcing the intended affiliation, many questions were raised by physicians and staff members. Foremost were potential layoffs of employees at both institutions and the question of whether or not one of the institutions would be closed following any affiliation. However the issue of reproductive access was also raised early on by physicians, and was covered in newspaper accounts of the affiliation agreement. Media coverage noted that if the affiliation took place, abortions and elective sterilizations would no longer be performed at Holyoke. Holyoke and Providence staff obstetrician-gynecologist Dr. Mark Singer is quoted as follows: "I think that if the women of Holyoke and the men are unable to receive complete health care, including reproductive care – and I'm not talking about abortions here – they will have lost something." (Pugh, 1994)

According to both Vincent McCorkle and Hank Porten, the reproductive access issue was addressed early on by participants in the affiliation discussions. In initial affiliation talks, participants examined issues that would constitute "deal breakers," and the issue of the loss of reproductive access was considered a potential deal breaker. However, McCorkle noted that the Holyoke community was over 50% Catholic, and members of both hospital boards were all Catholic, and a decision was made by the negotiating parties that this was a condition that they could all live with. (interview,

McCorkle, 2001) Porten noted that "the issue (reproductive access) was not creating any public angst, so we didn't follow it up." (interview, Porten, 2001) At this time, the only community input into the process was through the medical staff. According to Porten, "We reached out to the medical staff, contacting physicians to ask for data and asked them what the issues were." (interview, Porten, 2001) It is unclear what the response of the medical staff was to this inquiry. While the issue of reproductive health care services was raised by some physicians in media reports, it does not seem that those concerns were raised through this exercise.

Pre and Post-Affiliation Reproductive Services

At the time that affiliation talks were taking place, McCorkle estimates that no abortions or elective sterilizations were being done, or had been done at Holyoke in the past ten years and that both procedures were performed primarily in Springfield at Baystate Medical Center. (interview, McCorkle, 2001) Porten noted that Holyoke Hospital "had never operated as an abortion clinic" and that the only abortions performed there were done under conditions where there was "a clear clinical safety issue for the mother. Tubal ligations were generally performed after the birthing process." (interview, Porten, 2001) Newspaper accounts of the process quote Holyoke CEO Hank Porten as saying "only two abortions have been performed (at Holyoke Hospital) in the last five years." (McAuliffe, 1994) In a letter to then Department of Public Health Commissioner David Mulligan, Porten writes:

> "It is currently the community's clinical practice to refer abortions, nearly all of which are done on an outpatient basis, to physician practices in Springfield, Massachusetts...We are not aware of anything in the consolidation between the

Holyoke and Providence systems which can be expected to change current practice." (letter to DPH, Porten)

In a letter from the Greater Springfield National Organization for Women, board member Sandra Lawson notes that "Last year, 200 men chose elective sterilization (vasectomy) at Holyoke Hospital. While in some communities these services are provided in the urologist's office, in Holyoke they are not." (letter to DPH, Sandra Lawson)

Based on these anecdotal indicators, it appears that post affiliation access to abortion would remain unchanged, but tubal ligations after childbirth, and vasectomy services could potentially be seriously impacted following the merger.

Community Response

In January and February of 1995, over 100 letters in opposition to the affiliation were received by the Department of Public Health's Determination of Need Program. Because the Department of Public Health's Determination of Need process requires public notice of an affiliation or merger, and because the Determination of Need application was filed on February 10, 1995, it is likely, according to Patricia Collins of the Western Massachusetts Coalition for Reproductive Freedom, (interview, Collins, 2001) that these letters were written in response to this public notice. In addition to letters from private citizens, letters were received from Greater Springfield Chapter of the National Organization of Women, Holyoke Pediatric Associates, Springfield Medical Associates, Massachusetts Institute of Behavioral Medicine, Trinity United Methodist Church, United Congregational Church of Holyoke, Coalition for Reproductive Freedom, and the Massachusetts Civil Liberties Union Foundation. All of

these letters voiced concern over the issue of reproductive access. While the Determination of Need process allows for a public hearing if requested by the community, no request was made and no public hearing was ever held. (interview, Porten, 2001)

Negotiations Fall Apart

The affiliation negotiations continued through 1994, and, as noted above, in February of 1995 a Determination of Need application was filed. Writing on behalf of the Abortion Access Project and the Coalition for Choice, attorney Sarah Wunsch, of the Civil Liberties Union of Massachusetts asked that the Department of Health deny the Determination of Need application, on the basis of loss of access of reproductive services. Citing a lack of clarity in the application itself as to what services would be allowed and what services would be prohibited under the *Directives*, Wunsch questioned the applicant's statement that "no change in services is contemplated." (letter to DPH, Wunsch) She also questioned the assertion that the affiliation would promote "greater efficiency in the health care delivery system" noting that:

> "Efficiency is simply not served when a women who has given birth at Holyoke Hospital and wishes to have a tubal ligation is forced to have that procedure elsewhere and at another time; efficiency is not promoted when a women who is treated for rape is forced to go to another health care facility in order to obtain 'morning after' pills; efficiency is not promoted when a pregnant women being treated at Holyoke Hospital for an emergency is sent elsewhere for an abortion to be performed to save her life or health." (letter to DPH, Wunsch)

Despite letters from the public, the application was approved, with conditions, in March 1995. Approval by the Attorney General's office was received in April 1995 and the

affiliation seemed well on its way to completion. However, on June 14, 1995, the Union News reported that the merger plans had been canceled. (Zajac, 1995)

Chronology of the Merger between Neponset Valley Health System and Caritas Christi Health Care System

Background on Neponset Valley Health System (NVHS)

The Neponset Valley Health System (NVHS), consisting primarily of Norwood Hospital in Norwood Massachusetts, and Southwood Community Hospital in Norfolk, Massachusetts, served as a health care provider to the southwest suburban Boston communities of, Canton, Dedham, Easton, Foxborough, Franklin, Mansfield, Norfolk, Norwood, Plainville, Sharon, Walpole, Westwood and Wrentham. Organized as a non-profit corporation in 1986, Norwood Hospital was a 179 bed acute care facility, while Southwood Community Hospital was a 170 bed facility offering a more limited range of acute care services with a focus on behavioral medicine and oncology. Both hospitals offered emergency room services. The corporation was governed by a 22 member Board of Directors, twenty five percent of who were members of the medical staffs of either Norwood or Southwood Hospitals. The CEO of the Board at the time of the merger was Yolanda C. Landrau. (NVHS v. Scott Harshbarger, p.4)

Columbia/HCA Courts NVHS

In 1994, facing declining revenues, both real and projected, the organization began to consider either sale or affiliation options. A Task Force was formed by the NVHS Board in 1996 to explore available options, and in response to its Request for

Proposals, listened to presentations from Lifespan Corporation, OrNda Healthcorp, Beth Israel Hospital, New England Deaconess Hospital, Boston Medical Center, and Columbia HCA Healthcare Corporation. Narrowing the choices to Lifespan and Columbia, the Task Force negotiated intensely with Lifespan until January 1997, at which time the decision was made to go with Columbia, citing Columbia's "strong financial resources." An agreement was reached between Columbia/HCA and NVHS in May of 1997. Columbia/HCA would purchase NVHS for $58 million, in a deal in which Neponset Valley's $55 million in debt would be retired, and $15 million in improvements would be made to existing facilities. (NVHS v. Scott Harshbarger, p.5-17) Additionally, a threatened loss of $8 million in Medicare reimbursements would be averted if the merger could be completed by December of 1997. (Moylan, October 1997)

The Demise of the Columbia/NVHS Deal

This announcement, though publicly backed by employees and physicians (The Boston Globe, September 1997, The Daily Transcript Edition, October 1997) of NVHS, and presented as the only viable option to NVHS's financial problems by officials at NVHS, brought an immediate response from community health care advocates in the formation of the Neponset Valley Community Health Coalition (NVCHC). According to their mission statement, the Coalition will "advocate for the maintenance and enhancement of affordable, accessible, quality health care (including mental health) for all residents within the Neponset Valley Health Care System, particularly the unserved and underserved." (NVCHC fact sheet) Working with Health Law Advocates, a Boston based subsidiary of the nonprofit organization Healthcare for All, the coalition began to ask questions and raise public awareness about the Columbia/HCA merger. On the state

level, the Attorney General's office had recently begun to turn a more jaundiced eye towards mergers involving for profit health care corporations. This stemmed in large part from Columbia/HCA itself being the subject of a federal Medicare fraud probe.

Issues raised by both the Coalition and the Attorney General's office included concerns that the selling price of $58 million was too low, that there would be loss of local control of a community asset, (Daniel, October 1997) and public accusations that Columbia had sacrificed patient care to profit. Additionally, the federal investigation into alleged Medicare over-billing by Columbia was ongoing. In September of 1997, then Attorney General Scott Harshbarger announced that the merger would be put on hold pending further review of these issues. (Guarino, 1997)

Under mounting community pressure, and saddled with an ongoing federal investigation, Columbia/HCA pulled out of the deal with NVHS in October of 1997, citing a desire to slow down the company's growth, and in particular its expansion into the Massachusetts health care market, while it dealt with the federal investigation. The Board of Trustees of Neponset Valley Health System announced that it had "mutually agreed with Columbia to end negotiations for the purchase of (NVHS)." This announcement, which was characterized as "unexpected, unexplained, and disappointing" by Diana Franchitto, spokesperson for NVHS (Moylan, October 22, 1997) was viewed as an opportunity to rethink the merger process by the Coalition. Coalition members Kathy Ward and Phyllis Boucher both spoke of the positive aspects of the pullout for the community. Said Ward, "I would like to think of it as a second chance. Not many communities get a second chance and we did." According to Boucher, "the Coalition

should work with the NVHS Strategic Planning Task Force through the process to ensure that the health system remains in good hands." (Moylan, October 22,1997)

That second chance would come in a mere two weeks.

The Deal with Caritas

Facing a substantial loss in Medicare funds if a buyer or a partner could not be found by November 30th, NVHS and Caritas Christi Health Systems announced on November 4th that they had entered into a 30-day period of negotiations. As reported in several local newspapers, spokespersons for both NVHS and its Board spoke of the need to move quickly or risk losing the Medicare fund recapture. According to NVHS spokesperson Diane Franchitto, "NVHS 'does not have the luxury of time.'" (Moylan, p.3) Negotiating committee member Richard Gelerman said, "This proposal was the only one we thought had a possibility of being concluded by Nov. 30" (Peterson, p.8) As part of the negotiation agreement, NVHS had "agreed to a Caritas Christi stipulation that Neponset Valley facilities stop doing abortions or sterilizations." (Ackerman, 1997) The merger with NVHS "would give Caritas control of about 14 percent of all hospital beds in the Boston area, placing the organization in second place in market share." (Ackerman, p.1) Caritas president and CEO Michael Collins said, "Our ability to increase our share of the market is very important for maximizing resources to take care of patients." (Ackerman, p.1) According to Richard Doherty, Public Affairs Director at Caritas, the NVHS merger presented itself at the right time. Caritas was in a position in which "the system felt it needed to grow to be effective and to achieve economies of scale. Affiliations were needed to support community based health in key markets." (interview, Doherty, 2001)

The proposal for a full-asset merger caught many in the community by surprise, including the Coalition, which had expected to be a part of the renewed process. Coalition member Kathy Ward questioned the commitment of NVHS in including the community in the process. "They made a statement that they felt Caritas would continue with the values of the community. I have a question: how do they know what the values of the community are? How could they speak for community's values when they have left the community out of the process." (Moylan, p.3) Additionally, Coalition members expressed concern over the issue of the loss of reproductive services. The proposed merger and its prohibitions on reproductive care should, according to Ward, "raise questions for women, 'at the least.'" (Moylan, p.3) However, Coalition member Dr. Ray Breton was more optimistic. "Caritas, from our initial look, is very favorably looked upon" and noted that if there was "a possibility of recapturing the Medicare money, the Coalition would try to 'accelerate the process.'" (DeCesare, p.1)

Pre and Post Merger Reproductive Services

In terms of specific numbers, it is unclear as to how many abortions, elective sterilizations (male and female) were being done at Norwood Hospital prior to this merger. Newspaper accounts of the merger suggest the numbers were few in terms of abortions, and the Norwood Board of Health did not have those statistics. Additionally, it is often hard to capture actual numbers for abortions, as they are reported by Diagnosis Related Group (DRG), an insurance grouping system that categorizes and groups procedures which are similar in terms of time spent in hospital for the purpose of payment. Thus, regular D and C (dilation and curettage) would also fall into this category. What is fairly clear is that post merger, any services that were currently

available would be seriously impacted. According to the informational brochure put together by the NVCHC:

> "Procedures that cannot be performed include abortions, sterilizations, tubal ligations and vasectomies. Birth control, including condoms and emergency contraception, cannot be dispensed nor can information about birth control be supplied." (NVCHC Brochure, p.1)

A Completed Merger

According to Attorney Stephen Rosenfeld of Health Law Advocates, and Kathy Ward of the Neponset Valley Health Coalition, Caritas stated early on in the negotiation process that they were not interested in pursuing the merger unless they had the support of the Coalition. (interviews, Ward and Rosenfeld, 2001) Reproductive access was high on the Coalition's list of concerns. Coalition members wanted "a specific plan for access to reproductive services." (Daniel, 1997) Caritas officials were, according to Doherty, very clear about what services would and would not be available at NVHS post merger. There would be no attempt to "carve out something that was technically consistent" with the *Directives.* Additionally, they would not "be party to facilitating" the putting together of information on alternatives. (Doherty interview)

Following several public meetings, one sponsored by the Coalition and attended by Caritas CEO Michael Collins, and another, the Department of Public Health Public Hearing, the coalition voted 56-4 in favor of supporting the merger. (Moylan, November 25, 1997) According to Kathy Ward, this was a difficult decision.

> "We asked ourselves: Are we selling out by letting this merger take place? We couldn't let this go through without addressing this issue. Others weren't as concerned, but a small group of women on the Coalition were concerned. We took it upon ourselves to take care of this. No matter what your beliefs are, those services are part of basic health care services that are available to us as a nation,

and it is not right to take them away. We knew that what we were giving up would never come back." (Ward interview)

Those still in opposition continued to voice concerns over the issue of reproductive services. By way of addressing the issue, the Coalition with help from the Department of Public Health was "working to compile a list of alternate sites which (would) be made available to doctors and patients." (Daniel, 1997) This working relationship is evident in the Department of Public Health's Public Health Council meeting minutes of November 25, 1997:

> "Council Member Slemenda reiterated her concern about access to reproductive services for the residents of Neponset Valley. Ms. Nancy Ridley, Assistant Commissioner, Bureau of Health Quality Management replied, 'Should this proceed to closure by the 30th of this month there is a process that we will follow. Staff is going to hold a public hearing in December with the Community Coalition and other interested parties. I already spoke to Deborah Bero and Gail Douglas, who have been two very involved Coalition members on this exact issue, about being a part of that. Phyllis Boucher and her counterparts in other cities and towns will be invited to attend the meeting with Family Health Services in order to develop the educational and identification mechanisms of where those services are available to insure access.' Ms. Ridley said she would keep the Council updated on the process, especially at the six month period." (DPH, 1997)

However, Coalition legal counsel commented to the local press, "If the deal goes through, these procedures will not be done at Norwood and Southwood hospitals. This is a loss of services and people need to know that up front." (Daniel, 1997)

A Determination of Need application, supported by a letter from the Coalition, was filed with the Department of Public Health on November 3, 1997, and this application was approved, with conditions, on November 25, 1997. The conditions appear in Appendix C.

DETERMINATION OF NEED PROCESS

Massachusetts has, compared to other states, some of the strongest laws governing health care conversions, mergers and acquisitions. According to Attorney Stephen Rosenfeld of Health Law Advocates, a law firm that specializes in health care access issues, Massachusetts is "infinitely better than other states, in the services provided by the state, and in regulatory attitude." (interview, Rosenfeld, 2001) In 1974, a "Determination of Need" (DoN) process (105CMR 100.000) was created with the initial intent of limiting the building of too many hospitals, so in that respect, the law was anti-competitive. According to Rosenfeld, in Massachusetts, the least aggressive parts of the DON were utilized. When a license changes hands, the Department of Public Health, in the form of the Public Health Council, has to approve the change; it has to make a determination of need. The questions to be answered revolve around whether the merger is good for the community or bad for the community. If the merger may be good for the community, it may be approved "with conditions." (interview, Rosenfeld, 2001)

The Determination of Need process requires that public notice be given prior to filing an application. People wishing to comment on the application must do so by submitting written comments to the Department of Public Health within twenty days of the filing of the application. Additionally:

- No action may be taken until the application has been on file for at least 20 days.
- A public hearing must be scheduled if 10 residents in the applicant's service area request one in writing.
- The application is considered at the Public Health Council, and presentations by the applicant and those who made public comment can be heard.

A COMPARISON OF THE HOLYOKE AND CARITAS DETERMINATION OF NEED APPROVALS

Both Holyoke Hospital and NVHS received approvals on their Determination of Need applications. And both DoN applications were approved "with conditions." However, there was a major difference in the two approvals, relative to reproductive access issues. In the Holyoke approval letter, the following is stated regarding reproductive access:

> "Comments were received from over one hundred people, representing individuals, voluntary organizations, health care providers, and community agencies. A significant number of commenters expressed concern about the impact of the transfer of ownership on the availability of abortion and family planning services to residents of the Holyoke area.... That the Hospital will no longer provide abortion services based on the MOU (Memorandum of Understanding) is outside the scope of the DON review for a transfer of ownership, is not before the Department. Thus, Staff finds that these comments cannot be used as a basis for recommending denial or approval of the application." (DPH letter, 1995)

In the approval letter for the NVHS/Caritas merger, condition #7 states the following after noting concern over the elimination of reproductive services was an issue that was brought up at the public hearing:

> "The Department shall review compliance with the condition concerning governance, as well as compliance with community involvement, community health initiatives, community health benefits and *reproductive health care services."* (Italics added) (DPH letter, 1997)

Clearly, a shift in focus relative to the issue of reproductive access had occurred at the Department of Health. Steve Rosenfeld of Health Law Advocates says that this shift occurred in October of 1996, with the DPH deciding that it must ensure "a network of services." (interview, Rosenfeld, 2001) Former Department of Health Commissioner

David Mulligan confirmed this. He states; "It is fair to say that we made it part of the regulatory process that this issue had to be resolved." (interview, Mulligan, 2001)

CATHOLIC HEALTH CARE RESPONSE TO THE REPRODUCTIVE ACCESS ISSUE

Catholic health care has not been silent on the topics of reproductive access, hospital mergers, and attempts to place limits or regulations on this process, and has in fact been very vocal in its response to attempts at regulation that it sees as a threat to the Catholic health care mission. In forming policy, it is important to understand and take into consideration all stakeholder points of view. Thus, an understanding of the Catholic Church's perspective on these issues is important to this discussion, and may be gained by examining the following:

- the Church's stand on health care reform
- recent actions taken by the Church to counteract attempts by the AMA to pass a resolution on access to comprehensive reproductive health care
- comments made by local and national leaders in Catholic health care relative to reproductive access issues

National Catholic Leaders on Health Care Reform

In the broader health care reform discussion, the Catholic Church has called upon policy makers to use a values based framework for decision making that emphasizes the common good over individualism. The Reverend Michael Place, president and CEO of the Catholic Health Association of the United States, points to the Church's "consistent ethic of life (which) calls us to a deeper concern for all people, particularly the weak and vulnerable, whose dignity is threatened and whose potential is squelched by unjust situations, conditions, and laws that exist today." He contrasts this viewpoint with

today's "increasingly fragmented, individualistic, and market-driven healthcare system." (Catholic Health Association, November 1999)

Emphasis on the common good is also evident as a basis for the *Directives* in addressing the social responsibility of Catholic health care services. It is noted that:

> "Catholic health care ministry seeks to contribute to the common good. The common good is realized when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals." (*Directives*, p.6)

The Catholic Bishops Conference, relative to health care reform, also addresses the use of a common good framework as follows:

> "We believe the debate can be advanced by a continuing focus on the common good and a healthy respect for genuine pluralism. A reformed system must encourage the creative and renewed involvement of both the public and private sectors, including voluntary, religious, and nonprofit providers of care. It must also respect the religious and ethical values of both individuals and institutions involved in the health care system. We are deeply concerned that Catholic and other institutions with strong moral foundations may face increasing economic and regulatory pressures to compromise their moral principles and to participate in practices inconsistent with their commitment to human life." (United States Catholic Conference, p.4)

AMA Resolution 218

In June of 2000, members of the American Medical Association offered a resolution that would require "all hospitals providing perinatal services to offer a full range of reproductive services." (Catholic Health Association, June 2000) Catholic health care fought this measure on the grounds that it would, if passed, according to Reverend Michael Place, "eliminate Catholic healthcare from the provision of obstetrical services, and perhaps the fabric of healthcare, harming an already fragile healthcare system in this nation." Additionally, Place noted that the resolution was "fundamentally

at odds with American medicine's traditional respect for individual's rights and freedom of conscience." (Catholic Health Association, June 2000) Also arguing the right of conscience of Catholic health providers was Dr. Michael Collins, president and CEO of Caritas Health Care Systems, and chairperson-elect of the Catholic Health Association of the United States. "The resolution, if passed, would force AMA to advocate for legislation that would deny a right of conscience for Catholic physicians and every Catholic hospital, health system, and health plan in this country," said Collins. (Catholic Health Association, June 2000)

THE RESPONSE OF LOCAL AND NATIONAL CATHOLIC HEALTH CARE

Leaders to the Reproductive Access Issue

The public response by the Catholic Church to the issue of reproductive health care access seems to revolve around three major points. First, that Catholic health care should not have to provide services to which it is morally opposed, and second, that no hospital provides every service. Finally, Catholic health care leaders would like others to focus on what Catholic health care does, as opposed to what it does not do. These tenets are evident in print media responses to questions about reproductive access, and were espoused in interviews conducted in the course of this case study.

As part of a televised report on this issue by CBS's 60 Minutes, journalist Morley Safer interviewed Father Place. In response to questions about reproductive access following Catholic/non-Catholic mergers, Father Place replied, "All services are not provided everywhere. All women's services are not provided everywhere. We provide a

full range of services that are commensurate with our values." (Church, Medicine and Women)

In New York, attempts by advocacy groups to raise the issue of reproductive access following mergers was met with this response by John Kerry, executive director of the New York State Catholic Conference:

> "The culture and identity we so profoundly cherish in Catholic healthcare is in danger of being lost in certain areas of our nation. The bishops, religious congregations, and healthcare institutions have made good-faith efforts to achieve reasonable accommodations with those who seek to undermine our ability to exercise our constitutional rights." (Kerry, p. 1)

In interviews for this case study, both Vincent McCorkle, of Sisters of Providence Health System, and Richard Doherty of Caritas Health Care Systems made the point that not all hospitals offer all services. According to Doherty, "Every hospital in the country takes public monies and doesn't provide all services." (interview, Doherty, 2001) Both Doherty and McCorkle also voiced the desire that Catholic health care be seen for the many good things it does. McCorkle pointed to a program for children run by Providence Hospital that has a 99% Medicaid enrollment, and Doherty noted the quality of its general health care services delivered by a number of Caritas hospitals located in poor working class communities. Doherty also noted that many secular hospitals do not provide certain reproductive services, but activists do not target them. (interview, Doherty, 2001)

OTHER EXISTING LAWS AND REGULATIONS WITH APPLICATION TO THE MERGER PROCESS

Community Benefits Law

In 1993, a report by Professor Nancy Kane of the Harvard School of Public Health showed that many of Boston's nonprofit hospitals had built up large surplus cash reserve accounts. This report raised concerns about whether or not these hospitals were completely addressing the health care needs of their communities. In response to this concern, former Attorney General Scott Harshbarger issued "Community Benefit Guidelines for Nonprofit Acute Care Hospitals." Written in 1994 and enforced by the Attorney General's office, the guidelines were meant "to ensure that nonprofit hospitals (were) truly charitable and responsive to the needs of the community." (Health Care For All, p.3,-4) Each nonprofit hospital must:

- Publicly adopt a Community Benefits Mission Statement
- Assign staff to develop a Community Benefits Plan
- Establish a Community Benefits Advisory Group
- Adopt a plan, which has been developed as outlined below, submit it to the Attorney General's Office, and carry it out

Each nonprofit hospital, in partnership with the community must:

- Define what communities and groups will be served by the plan
- Identify health needs and develop priorities
- Develop plans and design programs to address the identified needs
- Review the plans accomplishments and shortcomings on a yearly basis (Health Care For All)

According to Rosenfeld, Community Benefits Laws are a "key way to keep an eye on institutions post-merger, and to preserve the safety net. Every non-profit hospital must

file a community benefits report each year. This is a way to make sure they continue to meet their community obligations." (interview, Rosenfeld, 2001)

> " On July 21, 2000, the Massachusetts Legislature passed Chapter 141 of the Acts of 2000. This bill was designed to "protect the rights of patients and to preserve the public health" from certain managed care practices. (Chapter 141, p.1) Section 2, Part 4 reads:access to such services following the hospital's closure of the service, and assure continuing access to such services in the event that the department determines that their closure will significantly reduce access to necessary services. The department shall conduct a public hearing prior to a determination on the closure of said essential services or of the hospital." (Chapter 141, p.3)

Chapter 141 of the Acts of 2000

Additionally, if the Department of Public Health determines that the discontinuance of the service will significantly reduce access to essential services, the hospital is required to submit a plan for assuring continued access. This new law has yet to be tested relative to reproductive access issues, but will certainly heighten public awareness regarding the loss of health services to the community.

FINDINGS RELATIVE TO REPRODUCTIVE ACCESS ISSUES IN THE HOLYOKE AND NVHS CASES

The issue of reproductive access played out in two entirely different ways in the cases included here, and yet both cases serve to illuminate and instruct relative to this issue.

Holyoke/Providence Affiliation

In the attempted affiliation of Holyoke Hospital and Providence Hospital, the affiliation attempt failed due to factors outside of the scope of reproductive access issues. Catholics for Free Choice reported the following in its synopsis of the Holyoke/Providence case:

> "Holyoke Hospital backed out of the deal because of concerns that a merger would result in the 'loss of services' at the non-Catholic campus by making the nearby Catholic hospital the dominant service provider, a spokesman for Holyoke Hospital said." (Bucar, 1999)

Results of this case study strongly suggest otherwise. Interviews with both Hank Porten of Holyoke and Vincent McCorkle of Providence describe a much different scenario. According to Vincent McCorkle, personal differences in management style between himself and Porten were more important to the disintegration of this deal than anything else. Both men were perceived to be strong personalities, and attempts to work out a management style they could both live with failed. (interview, McCorkle, 2001) Porten also points to management style differences, noting that one style was more participative while the other was non-participative. Porten also faults "stark cultural differences" and economic issues that "challenged the fundamental idea of whether this was good." (interview, Porten, 2001)

Former DPH Commissioner David Mulligan also "did not personally think reproductive access was the issue," noting that Providence Hospital was in a very weakened financial state, (interview, Mulligan, 2001) something that was not discovered by Holyoke officials until later in the process of negotiations. Because of concern over running afoul of anti-trust laws, the negotiations followed a due diligence process that involved very limited access to financial information acquired through third parties. When that information was finally made more available, Holyoke Hospital backed out of the deal. (interview, Porten, 2001) Sisters of Providence eventually filed a lawsuit against Holyoke Hospital because it withdrew from the proposed affiliation. The suit was settled for $6 million in legal costs, the money being paid by Holyoke Hospital to Providence Hospital. (interview, McCorkle, 2001)

This being said does not mean that reproductive access issues and how they were dealt with in this case were not an important part of this process. While it is not clear how this would have played out over time had financial and cultural issues not dealt this affiliation its death blow, clearly there was extensive concern, about this affiliation among community activists and other community members, who were familiar with the issues of reproductive access in these mergers. Large numbers of letters were received voicing concern over the loss of service. Advocates like Patricia Collins, of the Western Massachusetts Coalition for Reproductive Freedom, expressed very strong views six years later when interviewed. Her comments were as follows: "They (the Catholic Church) are subverting the lives of people with sometimes disastrous results. There should be at least one requirement, and that is that they have to make sure that there is someplace within a reasonable distance to go and get these services." (interview, Collins, 2001) From the beginning, the importance of these issues was discounted by officials at both institutions involved in the affiliation process. They assumed that because the majority of those in the community, and the majority of those involved in the affiliation process itself were Catholic, that reproductive access was a non-issue. Public involvement was limited to asking medical staff about their concerns, and members of the community were either unaware of or not yet organized enough to request a public hearing. The Determination of Need process had not yet evolved to the point where reproductive access was considered an issue to be dealt with by the Department of Public Health's Public Health Council during its review of a possible merger or affiliation. This scenario stands in stark contrast to how the issue of reproductive access was handled in the NVHS/Caritas merger three years later.

NVHS/Caritas Merger

Because NVHS had entertained a purchase proposal from a for-profit entity in Columbia/HCA, concerned community members were already involved in the process when Caritas Health Care System entered the picture. And they were well educated in the process, and well advised by Health Law Advocates. Community involvement in the form of the Neponset Valley Community Health Coalition ensured that the issue of access to reproductive health care was kept on the front burner during the merger process, and that it would be addressed. The shift by the Department of Public Health in its stance on giving reproductive access issues weight in the Determination of Need process also made sure that the issue was not buried. Given the time constraints involved in this merger, the Coalition, members of the Department of Public Health, lawyers from Health Law Advocates, and other concerned individuals were able to do a good job of trying to ensure that the community was educated about the loss of reproductive health services, and that information about alternative options was made available. (Appendix D)

POLICY IMPLICATIONS AND RECOMMENDATIONS

Policy makers must assume that the Catholic Church, in its role as a provider of health care services, has a particular framework from which it will operate regarding the provision of certain reproductive health care services. This framework will dictate the types of services that will be available following a Catholic/non-Catholic merger. In point of fact, there is some evidence that the Church is seeking to tighten its control over the merger process, and the way reproductive access issues are dealt with in that process. A recent article in Health Advocate reported that "At its annual meeting in November,

the National Conference of Catholic Bishops proposed revising the *Ethical and Religious Directive for Catholic Health Care Services* to further restrict non-Catholic hospitals from performing voluntary sterilizations." (Health Advocate, p.7) Vincent McCorkle of SPHS and Richard Doherty of Caritas both confirmed that the Catholic Bishops are looking at the *Directives* in an attempt to make them less inconsistent and more able to be universally interpreted from diocese to diocese. (interviews, McCorkle, Doherty, 2001) Over the past few years, many creative solutions have been devised to deal with the issue of access to reproductive health care in the course of these mergers. For example:

- An area is set aside in the facility for reproductive service delivery
- The Catholic partner agrees not to benefit monetarily from any income derived from reproductive health service delivery
- A "virtual merger" is created in which assets are not merged, and the *Directives* are therefore not enforced at the non-Catholic institution (Bucar, 1998, p.22)

This concern over tightening the application of the *Directives* may be a response to these "creative solutions" and if so, may signal that the Church will no longer tolerate what Richard Doherty of Caritas referred to as "an attempt to carve out something that was technically consistent with the *Directives.*" (interview, Doherty, 2001) In forming policy that will address the issue of access to reproductive health care, policy makers may have to look beyond past practices of working out "deals" with Catholic health care and take a more proactive approach to ensure access to these services is available following these mergers.

Policy makers should begin by examining existing law governing merger activity for areas that may be useful and applicable in regulating access. Specifically, the following three areas merit attention in this regard:

- The Department of Public Health's Determination of Need process

- The Attorney General's Community Benefits Guidelines
- The newly enacted Chapter 141 of the Acts of 2000 Managed Care Bill

Determination of Need

The Determination of Need process is already being used with some success in guiding mergers of this type, by attaching conditions to the DoN application regarding access to reproductive health care as was done in the Norwood/Caritas merger. (see Appendix C, condition #7) According to David Mulligan, the precedent set in Norwood was used in a later merger situation between Goddard and Cardinal Cushing Hospitals in Brockton to address the reproductive access issue there. (interview, Mulligan, 2001) And Kathy Ward notes that "since the inception of our DoN, every hospital has had to adhere to a standard that is more publicly oriented than corporately oriented." (interview, Ward, 2001)

The DoN process also includes consultation with the Division of Medical Assistance (DMA). The DMA must examine the proposed merger to ensure that the merger will not result in access problems for Medicaid recipients. In both the Holyoke and NVHS cases, the DMA signed off on the DoN, citing "no access problems for Medicaid recipients in the hospital's primary service area." (DPH letters, 1995, 1997) This part of the process should be explored as an area that may be useful in further regulating access to reproductive health care.

Community Benefits Guidelines

The Community Benefits Guidelines could also be more rigorously used in addressing the issues of access to reproductive health care. Through the Community Benefits process, hospitals in partnership with community members are supposed to identify and address unmet health needs. In Norwood, the Neponset Valley Community Health Coalition has, to their credit, maintained a close working relationship with Caritas through the Community Benefits process. While the issue of access to reproductive health care was addressed initially through the compilation of a list of alternative sites for care, the Coalition has not felt it necessary to revisit this issue for this community. According to Kathy Ward, the issue of reproductive access has not been raised as an issue by the largely Catholic community since the time of the merger. (interview, Ward, 2001) The Community Benefits Reports for 1998/1999 and 1999/2000 contain no references to reproductive access, although the Coalition is active in addressing such issues as Free Care and Mental Health. (Commitment to Care)

This does not mean that the Community Benefits process cannot be used to address reproductive access concerns. Community Benefits reporting is mandated and enforced by the Attorney General's office as a process in which non-profit hospitals should address unmet health needs. Thus, it would be entirely within the scope of the Community Benefits system to address issues of access to reproductive health care in this venue. However, none of the Community Benefits Reports examined as a part of this study used this process to that end.

Chapter 141 of the Acts of 2000

As yet untested in the area of reproductive health care access, but holding much promise, is the new law governing merger activity, Chapter 141 of the Acts of 2000. As describe above, this law proscribes a merger that would result in the loss or discontinuance of "essential services" from going forward without ensuring the replication of such services. On January 29, 2001, a public hearing was held by the Massachusetts Department of Public Health's Public Health Council concerning revisions to the existing definition of essential services. The original definition did not include mention of reproductive health services. As a result of that public hearing, the following changes to the definition were made in April of this year:

> "In response to (public hearing) comments, we have revised the definition of Essential Health Service to include outpatient dental services, outpatient psychiatric and mental health services, and outpatient reproductive health services, and to exclude chronic care services." (Dreyer, 2001)

Additional changes are also noteworthy in respect to the issue of monitoring and evaluating access following a merger. They are:

- The DPH Commissioner may, in "exceptional circumstances" decide to determine that a service not clearly defined, which may potentially be lost as part of a merger, is essential, thus opening the process up to public hearing.
- The addition of a requirement to monitor and report on the hospital's access plan as described above.

This law, given its most current revisions, is probably the strongest policy support to date on health care access issues. Those who are concerned about reproductive access issues should most certainly utilize its provisions.

Conscience Clauses

Massachusetts, like many other states, has provisions in state law which allow private hospitals to refuse to provide abortion, sterilization, and contraception services, if providing those services would violate their religious beliefs. (Gold, 2000) The American Civil Liberties Union has suggested that these provisions be more carefully examined and has proposed a framework for "assessing whether such exemptions should be permitted." (American Civil Liberties Union, 1999) The tenets of the framework are as follows:

- That religious exemptions should not be allowed when the exemption would result in "the imposition of religious tenets on others in a civil society."
- That religious exemptions should be allowed "when a law of general application would violate an institution's....religious tenets, and the granting of such an exemption would not work an imposition of those religious mandates upon third parties in the secular world." (American Civil Liberties Union, 1999)

Policy makers should examine existing conscientious exemption laws in Massachusetts for areas of weakness.

Additional Considerations

While strengthening the laws and policies that govern access to reproductive health care should be a priority, other factors should also be kept in mind. In the current health care environment, other health care access problems exist, and care should be taken so that policies aimed at improving access to reproductive health care do not have a negative effect on other health care access issues. Specifically, the closure of a community hospital can have negative effects on the community involved, relative to overall health care access for that community. Employment is also negatively impacted

within the community when a hospital is forced to close. There is much benefit in ensuring that these mergers can continue to take place, if necessary, while working out reproductive access issues.

The Role of Public Involvement

Massachusetts is fortunate to have had in place several laws or policies which have helped to guide the process of mergers between Catholic and non-Catholic hospitals before, during and after the process. In comparing these two cases however, the most striking observation is the inverse role community or public involvement played in the two cases examined. In the Holyoke case, over 100 letters of opposition citing reproductive access concerns were received by the Department of Public Health. While the affiliation eventually collapsed, it did not founder on the reproductive access issue. In Norwood, a small group of women, as part of a community coalition, made reproductive access a prime issue in a merger that was eventually completed. Central to the difference between the two cases is the evolution and role of public policy in Massachusetts in its awareness of reproductive access as a concern in mergers between Catholic and non-Catholic hospitals. In the Holyoke case, the advocate community was primarily responsible for raising the issue of access to reproductive health care services, and they did so in large numbers. Their concerns however, were not supported by broader public policy initiatives at the state level. There was no place in the existing public policy process for this issue to gain the footing necessary for the issue to rise to the level of public debate at that time. In the three years that elapsed between these two cases, that awareness had grown. Although there were a comparatively small number of committed

individuals in Norwood, public policy had evolved to the point where those individuals were supported in their positions through the policy process. In the future, policy makers should ensure that existing laws, and any new laws created, embody a strong requirement of public participation in mergers in which ANY loss of health care services is imminent.

CONCLUSION

Like so many policy questions, this one has no easy answers. It is a true policy paradox, where even the definition of community is debated. It is played out in symbols and numbers, the causes debated by interested parties, who try to influence a final solution which is expressed through, rules, facts, rights and powers, in order to meet the goals of equity and liberty. (Stone, 1997)

The Catholic Church claims that it provides health care in a way that is more in keeping with the needs of the community (the common good) than what is offered in today's individualistic health care market. We can only accept this argument if we agree with the Catholic Church's definition of community. While there is no question that Catholic health care provides much needed services in many communities, particularly some of the state's poorer communities, the question is raised as to who gets to define community relative to reproductive health care. In a Catholic hospital, which serves all members of society, does the Catholic Church get to define community and then subsequently provide or deny services based on that definition, or should the community be defined by a secular majority? If the Catholic Church defines the community, how does that impinge on the rights of men and women to receive reproductive health care

services? If the community is defined by a secular majority, how does that impinge on the rights of the Church to invoke its conscience clause?

Reproductive rights advocates and those representing Catholic health care interests argue these questions using numbers and symbols. How large is Catholic health care? How many Catholic institutions provide emergency contraception? Shouldn't Catholic health care be seen for its commitment to the poor? How do we protect a woman's right to choose? Whose rights should prevail?

Additionally, because current health care economics dictate that many hospitals must merge or affiliate in order to survive, and because survival ensures continued access to general health care services for a larger population, equity (continued access for many) must be weighed against liberty (reproductive access for women).

The role policy makers must play in this debate is three-fold. First they must, as was done in Norwood, ensure full public participation in the merger process, including pre-merger discussions about potential loss of reproductive services and the impact of that loss on the community, and information on how and where those services will be replicated. Secondly, because current research indicates that health care for women should be delivered in a comprehensive and integrated fashion, (Weisman, 1998) policy makers must ensure that, in the end, public policy supports and does not impede the implementation of identified best practices in the field of health care for women. Finally, public policy must hold hospitals accountable to the access issue by requiring a replication plan, as has been done in the revisions to Chapter 141. It is not enough to say that not all hospitals provide all services. (Doherty interview, 2001) While this may be true, in point of fact all hospitals have the *potential* to provide *any* service. A hospital

may not be currently providing a particular service (for example open-heart surgery), but if significant need arises in the community, the service can in theory be made available. Not so with access to reproductive health care services in Catholic hospitals. Once reproductive services are lost through a merger or an affiliation with a Catholic hospital, they are lost forever. And while the loss may seem insignificant taken in small increments, in total over time, the loss will be devastating to women's reproductive freedom.

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APPENDICES

Appendix A: Ethical and Religious Directives #36, 38-40

36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.[19].

38. When the marital act of sexual intercourse is not able to attain its procreative purpose, assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself, may be used to help married couples conceive.[27]

39. Those techniques of assisted conception that respect the unitive and procreative meanings of sexual intercourse and do not involve the destruction of human embryos, or their deliberate generation in such numbers that it is clearly envisaged that all cannot implant and some are simply being used to maximize the chances of others implanting, may be used as therapies for infertility.

40. Heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to parents and the child.

Source: Ethical and Religious Directives for Catholic Health Care Services

Appendix B: Trends in Birth Rates

Table 24.
Trends in Birth Rates Among Women Ages 15-19 for Selected Communities[1], Ranked by 1999 Teen Birth Rate[2,3] Massachusetts: 1999, 1998, 1990

1999 Rank	Demographic Area	1999		1998		1990	
		Number Births 15-19	Teen Birth Rate	Number Births 15-19	Teen Birth Rate	Number Births 15-19	Teen Birth Rate
	Massachusetts	5,515	26.6	5,823	28.1	7,258	35.1
1	Chelsea	90	107.5	100	119.5	105	114.8
2	Lawrence	277	103.9	298	111.8	338	122.8
3	Holyoke	147	100.5	189	129.3	203	140.3
4	Springfield	485	86.7	458	81.9	523	87.9
5	Southbridge	41	74.0	45	81.2	48	82.5
6	New Bedford	221	72.4	220	72.0	263	76.3
7	Lynn	174	67.9	191	74.5	194	79.4
8	Lowell	235	62.9	239	64.0	309	81.3
9	Brockton	169	60.9	178	64.1	216	67.8
10	Fitchburg	94	57.9	89	54.8	146	82.1
11	Taunton	83	53.0	70	44.7	95	61.0
12	Fall River	150	52.8	155	54.6	246	76.9
13	Leominster	60	52.1	49	42.6	42	37.8
14	Haverhill	82	49.6	80	48.4	94	60.4
15	Worcester	304	46.2	328	49.8	399	58.8
16	Boston	761	41.0	823	44.3	1,137	52.7
17	Somerville	64	38.5	60	36.1	64	29.2
18	Salem	46	37.4	49	39.8	45	35.4
19	Chicopee	63	36.5	70	40.6	84	44.9
20	Pittsfield	48	33.1	68	46.9	74	48.3
21	Methuen	42	32.8	47	36.7	53	41.7
22	Framingham	54	27.8	44	22.7	44	19.6
23	Plymouth	34	19.4	38	21.7	55	35.6
24	Quincy	34	16.9	46	22.9	51	22.0
25	Cambridge	44	14.5	31	10.2	54	14.9

Sources: Registry of Vital Records and Statistics, MDPH, BHRSE, 1998, 1999. The 1990 population data are based on the 1990 Census Massachusetts Age, Race and Sex File (MARS File).

[1] 25 communities with the greatest number of births to teens ages 15-19 in 1999

[2] Rates are per 1,000 females ages 15-19 in each city/town.

[3] Rates were recalculated using new population estimates for female teens ages 15-19. 1998 rates were re-calculated based on 1998 population estimates released in September 2000. 1999 rates were calculated with 1998 MISER estimates as 1999 population estimates are not yet available.

Source: Massachusetts Department of Public Health, *Adolescent Births: A Statistical Profile, Massachusetts 1999*, January 2001.

Appendix C

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Determination of Need Program
10 West Street, Boston, MA 02111
(617) 753-8130

ARGEO PAUL CELLUCCI
GOVERNOR

WILLIAM D. O'LEARY
SECRETARY

DWARD K. KOH, M.D., MPH
COMMISSIONER

July 23, 1998

Phyllis M. Boucher
Neponset Valley Community
Health Coalition
566 Washington Street
P.O. Box 40
Norwood, MA 02062

Re: Approved DoN Projects 4-3951 & 4-3952
Southwood Community & Norwood Hospitals
(Transfer of Ownership)

Dear Ms. Boucher:

The purpose of this letter is to request a status report on compliance with condition 7 of the attached Notice of Determination of Need, for the above referenced projects, issued on December 12, 1997. The condition addresses compliance with governance, community involvement, community health initiatives, community health benefits and reproductive health care services. Staff plans to submit a progress report to the Public Health Council at its September 15, 1998 meeting. The Coalition's status report should be submitted to this office no later than August 25, 1998.

If you have any questions, please contact me at (617) 753-8130.

Sincerely,

Joyce James
Program Director

Enclosure

cc: Public File
Program Analyst

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Determination of Need Program
10 West Street, Boston, MA 02111
(617) 753-8130

ARGEO PAUL CELLUCCI
GOVERNOR

WILLIAM D. O'LEARY
SECRETARY

)WARD K. KOH, M.D., MPH
COMMISSIONER

December 12, 1997

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Jeffrey L. Heidt
Choate, Hall & Stewart
Exchange Place
53 State Street
Boston, MA 02109

NOTICE OF DETERMINATION OF NEED
PROJECT NUMBER 4-3952
Transfer of Ownership of Norwood Hospital

Dear Mr. Heidt:

At their meeting of November 25, 1997, the Commissioner and the Public Health Council, acting together as the Department, voted pursuant to M.G.L. c.111, s.51 and the Regulations adopted thereunder, to approve with conditions the application filed by Caritas Norwood Hospital, Inc. for the transfer of ownership and original licensure of Norwood Hospital, resulting from a Memorandum of Understanding ("MOU") between Neponset Valley Health System, Inc. (NVHS), sole member of Norwood Hospital which owns and operates Norwood Hospital, and Caritas Christi, sole member of Caritas Norwood Hospital, Inc. Pursuant to the MOU, Norwood Hospital will merge into Caritas Norwood Hospital which will become the licensee of Norwood Hospital. No change in services and no capital expenditures are contemplated for this transfer of ownership. This Notice of Determination of Need incorporates by reference the Staff Summary and the Public Health Council proceedings concerning this application.

The reasons for this approval is that the application satisfies the standards applied under the Alternate Process for Change of Ownership, as listed at 105 CMR 100.602 of the Determination of Need Regulations as follows:

A. Individuals residing in the Hospital's primary service areas comprise a majority of the individuals responsible for decisions concerning:

1. approval of borrowings in excess of $500,000;
2. additions or conversions which constitute substantial change in services;
3. approval of capital and operating budgets; and

4. approval of the filing of an application for determination of need.

B. The Applicant has consulted with the Division of Medical Assistance (DMA) concerning the access of medical services to Medicaid recipients at the hospital. Comments from the DMA indicate no access problems for Medicaid recipients in the hospital's primary service areas.

C. The Division of Health Care Quality has determined that the Applicant and any health care facility affiliates have not been found to have engaged in a pattern or practice in violation of the provisions of M.G.L. c.111, s.51(D).

D. The Applicant has agreed to maintain or increase the percentage of gross patient service revenue allocated to free care, as defined at M.G.L. c. 118G or its successor statute covering uncompensated care, as existed prior to the transfer. The percentage of gross patient service revenue allocated to free care in calendar year 1996 was 2.6% for Norwood Hospital.

E. The Division of Health Care Quality has confirmed that the Applicant is an affiliate of a licensed facility.

A public hearing was held on November 17, 1997, at King Phillip Junior High School in Norfolk, MA. One hundred and eighty eight (188) people attended the hearing, thirty (30) of whom testified, including Caritas Christi, representatives of the Neponset Valley Health System, Inc., and members of the Neponset Valley Community Health Coalition. Almost all of the people who testified at the hearing supported the proposed merger. The Neponset Valley Community Health Coalition subsequently supported the merger in a letter to the Department. Issues presented at the public hearing included: capital financing and investment, indigent/free care, mental health services, reproductive health, emergency medical services, and collective bargaining. The applicant has agreed to address the charity concerns and has entered into an agreement with the Neponset Valley Community Health Coalition. This agreement is reflected in the conditions of approval to this determination of need.

This Determination is effective upon receipt of this Notice and is subject to the conditions indicated below. Failure of the applicant to comply with these conditions may result in Department sanctions, including fines and/or revocation of the DoN.

1. The Applicant agrees to maintain or increase the percentage of gross patient service revenue allocated to free care, as defined at M.G.L. c. 118G or its successor statute covering uncompensated care, as existed prior to the transfer. The percentage of gross patient service revenue allocated to free care shall be 2.6% for Norwood Hospital.

2. Free Care. Consistent with its charitable mission, Caritas agrees to continue to provide indigent and free care services consistent with applicable regulatory requirements. Within the first year of ownership, furthermore, Caritas agrees to establish a community process to examine whether additional education and outreach services covered by the Uncompensated Care Pool should be implemented and whether services, currently not covered under the Uncompensated Care Pool should be covered.

3. Governance. In fulfillment of Caritas' objective to obtain meaningful community participation in the governance of the Hospitals, Caritas will solicit from the community, including the Norfolk and Norwood Boards of Selectmen and the Boards of Health of the two Hospitals' service area communities, names of qualified candidates who could serve on the Board of Trustees. Fifty percent (50%) of the Board of Trustees will be filled in this manner. Furthermore, two (2) of the six (6) positions on the Caritas Board of Directors will be chosen from this fifty percent (50%) group from the community.

4. Mental Health Services. Caritas will exert all reasonable efforts to maintain the mental health services as currently provided by both Hospitals. This includes, subject to demand, Caritas maintaining at least twenty (20) locked psychiatric beds. If Caritas decides to eliminate or reduce these twenty beds, input in the related planning and decision-making will be sought from the community. Furthermore, Caritas agrees to establish and implement plans for dedicated mental health exit services, including, but not limited to counseling on housing, job placement and available social services.

5. Staffing. Caritas commits to maintaining adequate staffing levels with appropriate skill mix in all departments and on all shifts at both Hospitals. Furthermore, Caritas agrees to accept the Massachusetts Nurses Association agreement and to negotiate in good faith upon the expiration of its current term.

6. Landfill. Caritas agrees to acquire all property associated with the Southwood Community Hospital and to remediate the site in a timely manner, meeting its legal requirements.

7. The Department shall review compliance with the condition concerning governance, as well as compliance with community involvement, community health initiatives, community health benefits and reproductive health care services after a six month period. A report on the status of compliance shall be reported to the Public Health Council by Department staff after consultation with the Applicant, Caritas Christi, Neponset Valley Community Health Coalition, and other interested parties. Failure of the Applicant to achieve compliance shall be considered grounds for the Department to take appropriate enforcement action through remedies available under the laws of the Commonwealth.

JOHN W. McCORMACK INSTITUTE OF PUBLIC AFFAIRS

UNIVERSITY OF MASSACHUSETTS BOSTON

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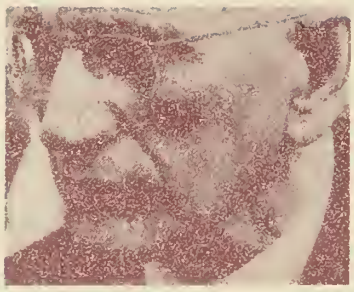

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